

**NEW YORK STATE DEPARTMENT OF HEALTH  
VITAL RECORDS SECTION**

**Application to Local Registrar  
for Copy of Death Record**

**Fee: County Districts - \$30.00 / Other Districts - \$10.00 per certified copy or No Record Certification**

**Identification Requirements:** Application *must* be submitted with copies of either A or B.

(Note: Copy of Passport required if request is made from a foreign country that requires a U.S. Passport for travel.)

A. One (1) of the following forms of valid **photo-ID**: **-OR-** B. Two (2) of the following showing the applicant's name and address:

- Driver license
- Non-driver photo-ID card
- Passport
- Employment ID

- Utility or telephone bills
- Letter from a government agency dated within the last six (6) months

|   |   |   |   |
|---|---|---|---|
| Name of Deceased:   |   |   | Social Security No. of Deceased:  |
| <div style="border: 1px solid black; height: 20px; width: 100%;"></div> | <div style="border: 1px solid black; height: 20px; width: 100%;"></div> | <div style="border: 1px solid black; height: 20px; width: 100%;"></div> | <div style="border: 1px solid black; height: 20px; width: 100%;"></div> |
| First   | Middle  | Last  |   |

|   |   |   |   |
|---|---|---|---|
| Date of Death or Period to be Covered by Search: (mm/dd/yyyy)           |   | Date of Birth of Deceased:  | Age at Death:   |
| <div style="border: 1px solid black; height: 20px; width: 100%;"></div> | <div style="border: 1px solid black; height: 20px; width: 100%;"></div> | <div style="border: 1px solid black; height: 20px; width: 100%;"></div> | <div style="border: 1px solid black; height: 20px; width: 100%;"></div> |
| From  | To  | mm / dd / yyyy  |   |

|   |   |   |   |
|---|---|---|---|
| Maiden Name of Mother of Deceased:                                      |   |   | Death Certificate No.: (If known)                                       |
| <div style="border: 1px solid black; height: 20px; width: 100%;"></div> | <div style="border: 1px solid black; height: 20px; width: 100%;"></div> | <div style="border: 1px solid black; height: 20px; width: 100%;"></div> | <div style="border: 1px solid black; height: 20px; width: 100%;"></div> |
| First   | Middle  | Maiden Last   |   |

|   |   |   |   |
|---|---|---|---|
| Name of Father of Deceased:   |   |   | Local Registration No.: (If known)                                      |
| <div style="border: 1px solid black; height: 20px; width: 100%;"></div> | <div style="border: 1px solid black; height: 20px; width: 100%;"></div> | <div style="border: 1px solid black; height: 20px; width: 100%;"></div> | <div style="border: 1px solid black; height: 20px; width: 100%;"></div> |
| First   | Middle  | Last  |   |

|   |   |   |
|---|---|---|
| Place of Death:   |   |   |
| <div style="border: 1px solid black; height: 20px; width: 100%;"></div> | <div style="border: 1px solid black; height: 20px; width: 100%;"></div> | <div style="border: 1px solid black; height: 20px; width: 100%;"></div> |
| Name of Hospital or Street Address                                      | Village, town or city   | County  |

|   |  |   |
|---|--|---|
| Number of Copies Requested: (For deaths occurring as of January 1, 1988 specify with or without confidential cause of death.)                           |  |   |
| Copies requested <b>with</b> confidential cause of death <div style="border: 1px solid black; width: 40px; height: 15px; display: inline-block;"></div> | Copies requested <b>without</b> confidential cause of death <div style="border: 1px solid black; width: 40px; height: 15px; display: inline-block;"></div> | Total number of copies requested <div style="border: 1px solid black; width: 60px; height: 15px; display: inline-block;"></div> |

|   |   |
|---|---|
| Purpose for which Record is Required:                                   | What is your relationship to person whose record is required?           |
| <div style="border: 1px solid black; height: 20px; width: 100%;"></div> | <div style="border: 1px solid black; height: 20px; width: 100%;"></div> |

|   |  |
|---|--|
| In what capacity are you acting?  | If attorney, give name and relationship of your client to person whose record is required: |
| <div style="border: 1px solid black; height: 20px; width: 100%;"></div> | <div style="border: 1px solid black; height: 20px; width: 100%;"></div>                    |

**If you are not the parent or child of the deceased or the spouse of the deceased at the time of death, you must submit documentation of a lawful right or claim.**

|  |   |       |     |      |  |  |  |   |
|--|---|-------|-----|------|--|--|--|---|
| Signature of Applicant: <div style="border: 1px solid black; height: 40px; width: 100%; margin-top: 10px;"></div>  | Date Signed:<br><table border="1" style="width: 100%; border-collapse: collapse; font-size: x-small;"> <tr> <td style="width: 33%;">Month</td> <td style="width: 33%;">Day</td> <td style="width: 33%;">Year</td> </tr> <tr> <td style="height: 20px;"></td> <td style="height: 20px;"></td> <td style="height: 20px;"></td> </tr> </table> | Month | Day | Year |  |  |  | <b>FOR REGISTRAR'S USE ONLY</b><br>(Photocopy ID and attach to application form)<br><br>Type of ID:<br><input type="checkbox"/> Driver License<br><br>Issuing state: _____<br><br>Expiration date: _____<br><br>Number: _____<br><br><input type="checkbox"/> Other ID, Specify<br><br>Number: _____<br><br>Type: _____<br><br>Number: _____<br><br>Type: _____ |
| Month  | Day   | Year  |     |      |  |  |  |   |
|  |   |       |     |      |  |  |  |   |
| Address of Applicant:<br><br><div style="border: 1px solid black; height: 20px; width: 100%; margin-bottom: 5px;"></div> <div style="font-size: x-small;">(Applicant's Name)</div> <div style="border: 1px solid black; height: 20px; width: 100%; margin-bottom: 5px;"></div> <div style="font-size: x-small;">(Street)</div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="border: 1px solid black; width: 25%; height: 20px;"></div> <div style="border: 1px solid black; width: 10%; height: 20px;"></div> <div style="border: 1px solid black; width: 65%; height: 20px;"></div> </div> <div style="display: flex; justify-content: space-between; font-size: x-small;"> <span>(City)</span> <span>(State)</span> <span>(Zip)</span> </div> <div style="margin-top: 10px;">         Telephone No.: ( <div style="border: 1px solid black; width: 30px; height: 15px; display: inline-block;"></div> ) <div style="border: 1px solid black; width: 100px; height: 15px; display: inline-block;"></div> </div> |   |       |     |      |  |  |  |   |